Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Fondren Orthopedic Group

Respondent Name
Liberty Mutual Fire Insurance

MFDR Tracking Number
M4-13-1502-01

Carrier's Austin Representative
Box Number 01

MFDR Date Received
February 15, 2013

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "We disagree with the amount paid as it appears that this claim not paid according to the 2012 TX Fee Schedule."

Amount in Dispute: $117.33

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Bill has been paid per Texas Fee Schdule."

Response Submitted by: Liberty Mutual

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
November 2, 2013	E0748	$117.33	$117.33

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.202 sets out medical fee guidelines for professional medical services provided in the Texas Workers' Compensation system.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 45 – The charge for this procedure exceeds the fee schedule allowance
   - B13 – Previously paid. Payment for this claim/service may have been provided ina previous payment.
   - 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.

Issues

1. Did the respondent support reason for reduction in payment?
2. Is the requestor entitled to reimbursement?

Findings

1. The carrier reduced the services in dispute as 45 – "The charge for this procedure exceeds the fee schedule allowance." Per 28 Texas Administrative Code §134.202(c)(2)(A) states in pertinent part, "125% of the fee listed for the code in the Medicare Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) fee schedule." Per the Medicare Pricing, Data Analysis and Coding (www.dmepdac.com) the allowable for E0748 is $4,179.10. This amount multiplied by $125% equals $5,223.88. The carrier paid $5,106.55. The carriers' reduction based on the Texas Fee Schedule is not supported.
2. Review of the submitted documentation finds the maximum allowable reimbursement (MAR) is $5,223.88. The carrier paid $5,106.55 leaving a balance due to the requestor of $117.33. This amount is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $117.33.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $117.33 plus applicable accrued interest per 28 Texas Administrative Code §134.130 due within 30 days of receipt of this Order.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	June 4, 2014 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.